Bureau of Health Care Quality and Compliance

| IDER OR SUPPLIER | NVS4409AGC | | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---|---|--|--|--|--|
| IDER OR SUPPLIER | | | A. BUILDING B. WING | | C 03/17/2011 | | | |
| .52.1 011 001 1 2.2.1 | | | | TE, ZIP CODE | 00/11/2011 | | | |
| SAINT EDANCIS CROUD HOME CARE 9 | | | ADDRESS, CITY, STATE, ZIP CODE VILDWOOD DRIVE EGAS, NV 89108 | | | | | |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | .D BE COMPLI | .ETE | | |
| Initial Comments | | | Y 000 | | | | | |
| The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/10/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. | | | | | | | | |
| The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was eight. Eight resident files were reviewed and three employee files were reviewed. | | | | | | | | |
| The facility received a grade of A. | | | | | | | | |
| he following deficien | cies were identified: | | | | | | | |
| 49.196(1)(f) Qualifica aining | ations of Caregiver-8 h | ours | Y 070 | | | | | |
| ncility must:) Receive annually no pours of training related on the needs of the residential facility. | ot less than 8 ed to providing esidents of a | v : | | | | | | |
| hyroxa hroicf haeese h h 4a A oo | tial Comments te findings and concert the Health Division on other claims ailable to any party ate, or local laws. This Statement of Defresult of an annual nducted in your facility for Group bed are sure survey was NRS 449.150, Power at the time of the sure survey was negative facility is licensed accility for Group bed are sure survey. The facility is licensed are facility received a survey was at the time of the survey was at the time of the survey was at the time of the survey was are facility received and the following deficient are following related to the needs of the residential facility. | tial Comments tial Comments te findings and conclusions of any investigations the Health Division shall not be construed oblibiting any criminal or civil investigations tions or other claims for relief that may be ailable to any party under applicable federate, or local laws. 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The following deficiencies were identified: 19.196(1)(f) Qualifications of Caregiver-8 houring and the caregiver of a residential cility must: 19.196(1)(f) Qualifications of Caregiver-8 houring and the residential cility must: 19.196(1)(f) Qualifications of Caregiver-8 houring related to providing the needs of the residents of a sidential facility. | tial Comments te findings and conclusions of any investigation the Health Division shall not be construed as phibiting any criminal or civil investigations, tions or other claims for relief that may be ailable to any party under applicable federal, ate, or local laws. This Statement of Deficiencies was generated as result of an annual State Licensure survey anducted in your facility on 3/10/11. This State censure survey was conducted by the authority NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential acility for Group beds for elderly and disabled arson and/or persons with mental illness. 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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---------------------------------|---|--|-------|----------------------------|---|-------------------------------|--------------------------|--|
| | | | | A. BUILDING B. WING | | С | | |
| NVS4409AGC | | | | | | 03/1 | 7/2011 | |
| NAME OF PROVIDER OR SUPPLIER | | | | RESS, CITY, STA | | | | |
| SAINT FRANCIS GROUP HOME CARE 8 | | 1604 WILDWOOD DRIVE LAS VEGAS, NV 89108 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| Y 070 | Continued From page 1 | | | Y 070 | | | | |
| | Based on record review on 3/10/11, the facility failed to ensure that 1 of 3 caregivers received eight hours of annual training (Employee #1) Severity: 2 Scope: 3 | | | | | | | |
| Y 859 SS=D | 449.274(5) Periodic Physical examination of a resident | | | Y 859 | | | | |
| | NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. | | | | | | | |
| | Based on record review | ot met as evidenced by: ew on 3/10/11 the facili 1 of 8 residents received ident #4). | ty | | | | | |
| | Severity: 2 Scope: | 1 | | | | | | |
| Y 878 SS=D | 449.2742(6)(a)(1) Me | edication / Change orde | r | Y 878 | | | | |
| | NAC 449.2742 6. Except as otherwis subsection, a medica physician must be ad | | ed by | | | | | |

Bureau of Health Care Quality and Compliance

| | | (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED C | | | |
|---------------------------------|---|---|--|---|--|------------------------------|--------------------------|--|--|
| NVS4409AGC | | | B. WING | | 03/17/2011 | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRE | SS, CITY, STA | ATE, ZIP CODE | • | | | |
| SAINT FRANCIS GROUP HOME CARE 8 | | | 1604 WILDWOOD DRIVE LAS VEGAS, NV 89108 | | | | | | |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | | |
| Y 878 | Continued From page | 2 | | Y 878 | | | | | |
| | the physician. If a physician the amount or times no administered to a resi | ysician orders a changenedication is to be dent: bonsible for assisting in medication shall: | | | | | | | |
| V 036 | Based on observation review on 3/10/11, the administer as needed prescribed for 1 of 8 r medications were not (Resident # 3) Severity: 2 Scope: 1 | e facility would be unab (PRN) medications as esidents because their available in the facility | ele to | V 036 | | | | | |
| Y 936 SS=D | resident of a residenti least 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, assess information and any of the resident, including (e) Evidence of components of the pursuant the sadopted pursuant the | at be maintained for each all facility and retained permanently leaves the be kept locked in a plat and is protected again the file must contain all assments, medical of their information related without limitation: liance with the provision and the regulations reto. | ch for at e ce st d to | Y 936 | | | | | |
| | This Regulation is no | t met as evidenced by: | | | | | | | |

Bureau of Health Care Quality and Compliance

| | | (X1) PROVIDER/SUPPLIER/G | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | | | | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| Y 936 | Continued From page | 3 | | Y 936 | | | | |
| | Based on record review on 3/10/11, the facility failed to ensure 1 of 8 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #4) which affected all residents. | | | | | | | |
| | Severity: 2 Scope: | 1 | | | | | | |
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